Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH LLC
5445 LA SIERRA DR #204
DALLAS TX 75231

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-10-1160-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provided and there was a recommended allowance of $104.00 per the attached EOB. We then received payment of $72.00 which is not what was recommended."

Amount in Dispute: $ 64.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: On October 22, 2009, a notice was placed in the carrier's Box #42. No response received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 5 and 10, 2009	90806	$ 64.00	$64.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §413.011(d-1) sets out the requirement for carriers to provide copies of contracts.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional services provided on or after March 1, 2008.
4. The service in dispute was reduced/denied by the respondent with the following reason code(s):
   - 45: charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 100: any network reduction is in accordance with the network referenced above
   - 113-001: network import repricing – contracted provider

Issues

1. Did the requestor have a contracted/legislated fee arrangement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement based upon "45 - charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement; 100 - any network reduction is in accordance with the network referenced above; and 113-001 - network import repricing – contracted provider". Former Texas Labor Code §413.011(d-1) states, in pertinent part, that "…an insurance carrier may pay fees to a health care provider that are inconsistent with the fee guidelines adopted by the Division if the insurance carrier…has a contract with the health care provider and that contract includes a specific fee schedule…" On August 5, 2010 the Division requested additional information. Specifically, medical fee dispute resolution requested a copy of the contract between the informal/voluntary network and Texas Health; and documentation to support that the requestor was notified in accordance with commissioner rule 28 Texas Administrative Code §133.4 titled Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks. The respondent failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed according to 28 Texas Administrative Code §134.203.
2. The Division recommends additional reimbursement as follows:
   - $53.68÷$36.0666 x $94.36 = $140.44 minus carrier previous payment of $72.00 = $68.44 x 2 dates of services = $136.88; the requestor seeks $32.00 x 2 dates of service = $64.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $64.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $64.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April , 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.